MEDICATION FORM FOR MIDCOAST AREA SCHOOLS

1. Medication must be in the original container, properly labeled with the name of the student and dosage.

2. ANTIBIOTICS PRESCRIBED 3X A DAY WILL NOT BE GIVEN AT SCHOOL UNLESS SPECIFICALLY REQUESTED BY A PHYSICIAN.

3. All medication will be given at lunch time unless otherwise specified.

4. If the medication is a self-administered inhaler, please write the number of puffs and frequency on dosage line (#4).

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I am aware that there may not be a registered nurse in each school. The student named below is in need of medication during regular school hours in order to maintain his/her health. If a nurse is not available, I request that non-medical personnel give the medication.

PARENT SIGNATURE: ________________________________ DATE:____________

* * TO BE COMPLETED BY PHYSICIAN * *

1. Student's name _______________________________________ Grade _______
2. Medication ____
3. Reason for Medication ____
4. Dosage ____
5. Time to be given (all medications will be given at lunch time unless specified otherwise here) ____
6. Duration of medication ____
7. Significant side effects ____

Physician's signature ____

Phone Number ___________________________ Date _______________________